IN THE THIRD JUDICIAL DISTRICT COURT
IN AND FOR THE COUNTY OF SALT LAKE, STATE OF UTAH

STATE OF UTAH, Plaintiff, vs. WANDA BARZEE, Defendant.	**RULING ON MOTION TO COMPEL MEDICATION** Case No. 031901886 Judge Judith S. Atherton

This case is before the court on the State's Motion to Compel Medication. At a hearing on February 16, 2006. Defendant was present with her attorneys Scott Williams and David Finlayson. The State was represented by Clark Harms, Alicia Cook, and Kent Morgan. The court has reviewed the parties' memoranda, the relevant case law, and all applicable statutory provisions.

Procedural History

On March 18, 2003, Defendant was charged with two counts of aggravated sexual assault, two counts of aggravated burglary, one count of aggravated kidnaping, and one count of attempted aggravated kidnaping (or in the alternative, conspiracy to commit aggravated kidnaping). On April 9, 2003, this court granted Defendant's stipulated petition to inquire into Defendant's competency to proceed. Dr. Nancy B. Cohn and Dr. Jeffrey A. Kovnick evaluated defendant, and, in November of 2003, both determined that

Defendant suffered from a mental illness and was incompetent to proceed. The parties stipulated to their findings, and, on January 9, 2004, the court found Defendant incompetent to proceed. Defendant was transported to the Utah State Hospital (State Hospital).

At a review on August 10, 2004, after hearing testimony from Dr. Gerald Berge and argument from the parties, the court concluded that Defendant was still incompetent to proceed, but that there was a substantial probability that she may become competent in the foreseeable future. On September 16, 2005, the court conducted a second scheduled competency review hearing and, after hearing testimony from Dr. Eric Nielsen, determined that Defendant was still incompetent to proceed. On October 14, 2005, the State filed a motion for a medication hearing and for forced medication of Defendant. After the February 16, 2006 hearing, the parties filed additional memoranda.

Relevant Facts

I. Dr. Nancy Cohen and Dr. Jeffery Kovnick

In November, 2004, both Dr. Cohn and Dr. Kovnick concluded that Defendant suffered from a mental illness that rendered her incompetent to proceed under section 77-15-5, Utah Code Ann. (1953, as amended). According to Dr. Cohn, Defendant demonstrated multiple indications of a psychotic mental disorder, including

delusional thinking, and she diagnosed defendant with Paranoid Schizophrenia.[1] Dr. Cohn concluded that, while Defendant's deeply entrenched delusional beliefs are among the most refractory to pharmacological intervention, administering antipsychotic medications to Defendant could potentially play some role in achieving competency for her.

According to Dr. Kovnick, Defendant suffers from a Shared Psychotic Disorder with signs and symptoms of a Delusional Disorder arising from her dependent and pathological relationship with her husband, Brian David Mitchell. Dr. Kovnick stated that in recent years the use of antipsychotic medications to treat Delusional Disorder has found increasing favor and, therefore, that medicating Defendant with antipsychotic drugs may help in the dissolution of her delusional beliefs.

II. Dr. Gerald Berge

On August 10, 2004, at Defendant's 90 day competency review, Dr. Gerald Berge, Defendant's treating psychologist at the State Hospital forensic unit, agreed with Dr. Kovnick that Defendant was suffering from a Shared Delusional Disorder, even though her delusions had persisted after her separation from Brian David Mitchell. Dr. Berge believed that it is possible, though unlikely,

[1]However, notwithstanding the presence of delusional thinking, Dr. Cohn ruled out a diagnosis of Delusional Disorder and Shared Psychotic Disorder (i.e., folie a'deux).

for Defendant's delusional beliefs to abate over time so long as she remains separated from Mr. Mitchell. According to Dr. Berge, while Defendant's competency had improved, she remained incompetent to proceed. The State Hospital had offered Defendant several treatment modalities, including individual and group therapy, but she had opted not to participate. The hospital had not medicated Defendant, and Dr. Berge did not know whether the administration of antipsychotic medication would have a beneficial effect in restoring Defendant's competency.

III. Dr. Eric Nielsen

Following Defendant's recommitment to the State Hospital, Dr. Eric Nielsen performed a competency evaluation. He interviewed Defendant on four separate occasions and testified at Defendant's next competency review hearing, held on September 16, 2005. Dr. Nielsen concluded that Defendant was suffering from a substantial mental illness manifested primarily by grandiose delusional beliefs. He found that the most appropriate diagnosis for Defendant was Psychotic Disorder, Not Otherwise Specified ("Psychotic Disorder, NOS"), concluding that Defendant was incompetent to proceed because her delusional beliefs prevented her from engaging in reasoned choice about her legal strategies and options and would also prevent her from testifying relevantly. He concluded that Defendant had shown no significant progress toward

competency from the time she was first ordered into treatment. She continued to refuse medication and refused to actively participate in therapy programs. However, Dr. Nielsen did not know whether medicating Defendant would result in a restoration of competency because he believed that most people whose symptoms were primarily of a delusional nature do not respond favorably to antipsychotic medication. Nevertheless, he also felt that certain aspects of Defendant's thought disorder, such as the vague, rambling quality of her speech, her unresponsiveness to questions, and the need to continually derail any conversation not associated with her delusional beliefs, are atypical of people who are strictly afflicted with a delusional disorder and more akin to persons with schizophrenic symptoms. Accordingly, those qualities suggested the possibility of a more positive response to psychotropic medication.

Dr. Nielsen believed that Defendant would not be restored to competency without the use of antipsychotic medication, noting that the likelihood of antipsychotic medication restoring a person to competency typically lessened the longer a person suffered from psychotic symptoms. Finally, Dr. Nielsen concluded that while Defendant remained at the State Hospital she posed no serious potential harm to herself or others.

IV. Dr. Kreg Jeppson

Dr. Kreg Jeppson is a psychiatrist in the forensic unit at the

State Hospital and, with the exception of a two-month period, has been Defendant's treating physician since March of 2004. When Defendant was first admitted, he diagnosed her with Delusional Disorder. However, Defendant has not fully cooperated with attempts to gain additional information about her psychological condition (e.g. refusing to submit to a neuroconsult or an MRI of her brain). Thus, despite his original diagnosis, over time and as a result of a change in symptoms, particularly the onset of referential thinking, he developed a working diagnosis of Psychotic Disorder, NOS, finding her mental illness to be characterized by grandiose and persecutory delusions, paranoia, thought disorder, and referential thinking. According to Dr. Jeppson, while Defendant concedes that people view her beliefs as odd or different, she does not believe that she suffers from a mental illness or that her thinking is delusional or that she needs psychological or psychiatric treatment. Defendant believes that those involved in her care at the State Hospital are "evil" and are "working against God's plan." She believes it is God's will that she not participate in treatment. As a result, she has rejected each treatment modality offered, including individual therapy, group therapy, and voluntary medication, believing that "Jesus" is the only medicine she needs. In light of Defendant's unwillingness to participate in treatment, she has made little, if any, progress towards restoration of competency.

Dr. Jeppson's standard practice is to administer antipsychotic medication to patients exhibiting the types of symptoms displayed by Defendant,[2] and that without the administration of antipsychotic medication Defendant is unlikely to make any further progress towards restoration of competency or to experience amelioration of her mental illness. Dr. Jeppson would try one, two, or three drugs individually at various doses. If no signs of improvement resulted, he would then start to combine the drugs. He would begin his treatment with 1 milligram of Risperdal once a day. He would then titrate the dose up to 3 or 4 milligrams a day over the course of three or four months. If there was only moderate improvement, he might increase the dosage up to 5 milligrams daily. If no improvement was indicated, he would stop using Risperdal and begin administering 100 milligrams of Seroquel daily. Over the course of weeks, he would increase the dosage to 400 milligrams per day and sustain this for three to four months. If no improvement was made, he would then either combine dosages of Risperdal and Seroquel or, perhaps, switch to Zyprexa.

Several side effects, including fatigue or sedation, weight gain, possible rise in cholesterol levels, diabetes, dry mouth, constipation, and orthostatic hypotension, would likely accompany the use of antipsychotic medications, although none would dissuade

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[2]Dr. Jeppson also testified that in his experience, even persons suffering from Delusional Disorder, Grandiose Type, can be successfully treated with medication.

him from medicating Defendant. Dr. Jeppson also believed that most of the side effects would be time-limited and could be mitigated through careful monitoring. Unlikely side effects include tardive dyskinesia and increased risk of heart attack. The use of antipsychotic medication would not undermine Defendant's ability to consult with her attorneys and, if the medication is successful, she would have an increased ability to engage in rational decision making about her case.

Although the drugs would not eliminate her mental illness or her delusions, they would assist her in becoming more cooperative and more concerned about her treatment and day-to-day activities by reducing both the intensity of, and her preoccupation with, her delusional beliefs. He found that involuntarily medicating Defendant would be in her best medical interest because the medication would give her a fuller, more functional life and would allow her to proceed forward with her case. Defendant's present unwillingness to cooperate has made it difficult for hospital staff to ensure the maintenance of her basic health needs. Without the involuntary administration of medication, Defendant would simply be warehoused at the State Hospital without any treatment or care designed to improve her competency or her overall well-being. He further felt that medication had a 70% to 80% likelihood of restoring Defendant's competence and would likely take eight to twelve months with signs of improvement probably occurring within

two to four months. Finally, Dr. Jeppson concluded that Defendant is neither gravely disabled nor an immediate danger to herself or others so long as she remains in the controlled environment of the State Hospital.

V. Dr. Paul Whitehead

Dr. Paul Whitehead is a psychiatrist in the forensic unit at the State Hospital and has consulted with Dr. Jeppson concerning Defendant's diagnosis and treatment. Dr. Whitehead agrees with Dr. Jeppson in every relevant area. Based upon his own assessment of Defendant's symptoms, he believes that the diagnosis of Psychotic Disorder, NOS is reasonable, particularly in light of her lack of cooperation in the evaluation process and in describing her experiences and her unwillingness to see a neurologist or participate in any type of psychological testing. Based upon his own evaluation of Defendant, he believes that Delusional Disorder is not the most accurate diagnosis because she exhibits more symptoms than a typical patient with that diagnosis

Dr. Whitehead agrees that medication is the cornerstone of treatment for patients with a psychotic disorder because it helps reduce psychotic thinking, normalizes the thought process, and, in Defendant's case, is essential to reducing her psychotic symptoms. Dr. Whitehead believes that Dr. Jeppson's treatment plan is a reasonable approach to administering medication to Defendant and

that the medication's likely side effects would not dissuade him from medicating her. Medication would help Defendant organize her thoughts, think rationally, and, thereby, better consult with her attorneys and prepare a meaningful defense. He concluded that it is substantially likely that Defendant will be restored to competency through the administration of antipsychotic medication and is necessary for her to progress toward competency restoration.

VI. Dr. Raphael Morris

Dr. Raphael Morris is a forensic psychiatrist with a private practice in San Diego, California. For the past ten years he has both treated and evaluated patients who required competency restoration. Dr. Morris has been the director of forensic services at Bellevue Hospital Center in New York City where he was in charge of forensic evaluations and treatment of inmates. He has also worked at the Kirby Forensic Psychiatric Center in New York treating patients who were not responding to medication, and he has been a treating psychiatrist at Sing Sing Correctional Facility. Dr. Morris has performed over one hundred competency restoration evaluations and has testified as an expert in numerous cases where involuntary medication was an issue. Based upon his experience and his assessment of Defendant, he disagrees with Dr. Jeppson that Defendant has Psychotic Disorder, NOS and believes the more accurate diagnosis is Delusional Disorder or, possibly,

Schizophrenia.

Dr. Morris challenged Dr. Jeppson's conclusion that Defendant has Psychotic Disorder, NOS because she exhibits symptoms of referential thinking. According to Dr. Morris, nothing about referential thinking precludes a diagnosis of Delusional Disorder. Significantly, Dr. Morris believes that Defendant's problem is not so much the delusional ideas themselves but the way in which they dominate her life. If she was not so preoccupied with her delusions, she might be able to talk about and better weigh her legal options separate from her delusions. However, although Dr. Morris did not expressly disagree with the antipsychotic medications Dr. Jeppson testified he would administer to Defendant, he did testify that the treatment plan for Defendant was less than ideal. This is so, he asserted, because the dosage amounts of the medications to be administered were inconsistent with the manufacturer's recommendations and, therefore, would simply be ineffective in restoring Defendant to competency.

For several reasons Dr. Morris believes that the administration of antipsychotic medications has only a 25% to 35% chance of restoring Defendant to competency. First, Defendant's thought processes are dominated by her delusions, and antipsychotic medication would not eliminate these. Because Defendant's incompetency is based directly upon her delusions, the administration of antipsychotic medication would likely not have a

marked impact on her competence to proceed. Second, generally, the longer a person's delusional thinking has gone untreated, the less likely antipsychotic medication would result in improved competency. In Defendant's case, her delusions have not been treated for nearly thirteen years. Therefore, in his view, successful treatment with antipsychotic medication is highly unlikely. Finally, Defendant has been previously diagnosed with Delusional Disorder, Grandiose Type. According to Dr. Morris, it is well-accepted by the psychiatric community that antipsychotic medication does not work well in treating persons with this type of psychotic disorder.

In addition, Dr. Morris believes that it is distinctly possible that the administration of antipsychotic medication would result in severe side effects including tardive dyskinesia, which can be permanent, weight gain, sedation, diabetes, heart problems, and orthostatic hypotension. This possibility, in combination with the limited likelihood that Defendant would respond favorably to antipsychotic medication, simply does not justify medicating Defendant against her will. Nevertheless, under cross-examination Dr. Morris testified that despite the various reasons in support of his conclusion that antipsychotic medication will not restore Defendant to competency, if Defendant were his patient he would treat her with antipsychotic drugs despite the risk factors. He also testified that medicating Defendant would be medically

appropriate and conceded that it is possible that medicating Defendant could prove helpful.

VII. Dr. Xavier Amador

Dr. Xavier Amador is a practicing clinical psychologist in the State of New York and an adjunct Professor of Psychology at Columbia University. He has over twenty years of clinical experience evaluating and diagnosing persons with psychotic and mood disorders in a variety of contexts, including the criminal justice setting. He has directly evaluated and treated, supervised evaluations and treatment of, or conducted clinical research on, more than 1,000 patients with clinical histories like that of defendant, who have a decade or more of untreated psychosis not characterized by prominent delusions. In addition to his clinical experience, Dr. Amador has been involved in research and studies addressing the treatment of patients whose symptoms are unresponsive to medication. He has also edited books, acted as a peer reviewer for approximately twenty journals in psychiatry, authored or co-authored more than 100 peer-reviewed articles, assisted in the revision of relevant sections of the DSM-IV, and consulted on drug trials with various drug companies. Dr. Amador is not a forensic psychologist and has never worked on restoring patients to competency in the context of a criminal case.

According to Dr. Amador, although Drs. Cohen and Kovnick gave

differing diagnoses, each diagnosis falls within the ambit of psychotic disorder and, in addition, all of the evaluators concluded that Defendant was suffering from severe grandiose delusions with religious themes. He was, however, perplexed by the diagnosis of Psychotic Disorder, NOS provided by Drs. Jeppson and Whitehead because the very reason for giving this diagnosis, namely, referential thinking by Defendant, does not preclude a diagnosis of Delusional Disorder. Based upon his own assessment of Defendant, he has diagnosed her with Delusional Disorder, Grandiose Type. Dr. Amador testified that the particular diagnosis rendered has some relevance to predicting successful treatment with antipsychotic medication.

Dr. Amador testified that the length of time from the onset of the mental illness to the first treatment is an important predictor in determining whether a patient will respond to treatment from antipsychotic medication. The longer the time period from onset to first treatment, the less likely the administration of antipsychotic medication will have a successful impact. According to Dr. Amador, research shows that after approximately one year of untreated psychosis, patients typically do not respond. This is a significant factor with respect to Defendant because her psychotic disorder has gone untreated for thirteen years or more. Thus, the prognosis for successful treatment with medication on the basis of duration of untreated

psychosis is not good.

In addition, Dr. Amador testified that his own clinical experience, as well as authoritative research data, shows that grandiose delusions are the most resistant to treatment with antipsychotic medications. Defendant's grandiose religious delusions, specifically her belief that God controls everything she does, will not change even with the administration of medication. Dr. Amador agrees with Dr. Jeppson that the administration of medication will make Defendant feel less inclined to talk about her delusions, but that her delusions would always be present. However, feeling less inclined to talk about one's delusions is not the same as restoring a person to competency. Only if the medication reduces the severity of one's delusions could it result in a restoration of competence.

Dr. Amador acknowledged that patients diagnosed with Delusional Disorder can be successfully treated, that patients with grandiose delusions can become competent, that involuntary medication can help mentally ill persons improve, and that if he could, he would medicate Defendant in order to restore her to competency. Nevertheless, he remains firm in his belief that <u>forcibly</u> medicating Defendant would be traumatic for her and would likely send her into a depression and make her vulnerable to symptoms of stress reaction and, potentially, Post-Traumatic Stress Disorder. Dr. Amador concluded that it is not substantially likely

that the administration of antipsychotic medication would reduce the severity of Defendant's delusions. He estimated that there is approximately a 20% chance of successful treatment for a diagnosis of Delusional Disorder and a 30% chance of success for a diagnosis of Psychotic Disorder, NOS. Indeed, he reports that even though he has been involved in the treatment of hundreds of patients with clinical histories similar to Defendant's, he has not yet met a patient with such a long a history of untreated delusions who has responded to antipsychotic medication.

Legal Analysis

Defendants who have been found incompetent to proceed to trial have a liberty interest in being free from unwanted medication. See U.S. Const., Amend. V (the State may not "deprive" a person of "liberty . . . without due process of law."). See also Washington v. Harper, 494 U.S. 210, 211 (1990) (recognizing "a significant liberty interest in avoiding the unwanted administration of anti-psychotic drugs"); Riggins v. Nevada, 504 U.S. 127, 134 (1992) (same). Nevertheless, United States Supreme Court has established a legal framework whereby a defendant's liberty interest may be overcome.

The Constitution permits the State to forcibly administer antipsychotic drugs to render an incompetent defendant facing serious criminal charges competent to stand trial. Sell v. United

States, 539 U.S. 166 (2003) The State must show by clear and convincing evidence[3] that the treatment is medically appropriate, substantially unlikely to have side effects that will undermine the fairness of the defendant's trial, and, in the absence of less intrusive alternatives, is necessary to significantly further important governmental trial-related interests. Id. at 179. A court must apply a four-part balancing test.[4]

"First, [the] court must find that important [State] interests are at stake." Id. at 180 (emphasis removed). See also Utah Code Ann. § 77-15-6.5(4)(d)(I). Bringing to trial a defendant who has been charged with a serious crime is an important State interest.

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[3]Although the United States Supreme Court did not address in Sell what standard of proof applies to the factors that must be considered, the Second Circuit Court of Appeals has concluded that the required findings must be supported by clear and convincing evidence. See United States v. Gomes, 387 F.3d 157, 160 (2nd Cir. 2004) ("[T]he relevant findings [under Sell] must be supported by clear and convincing evidence."). In United States v. Bradley, 417 F.3d 1107 (10th Cir. 2005) the Tenth Circuit agreed. See id at 1114 ("The Second Circuit determined the remaining Sell factors depend upon factual findings and ought to be proved by the government by clear and convincing evidence. Recognizing the vital constitutional liberty interest at stake, we agree."). In addition, recent legislation enacted by the Utah Legislature specifically states that "the court [must] find[] by clear and convincing evidence that the involuntary administration of antipsychotic medication is appropriate," Utah Code Ann. § 77-15-6.5(6)(a), before it permits a defendant to be medicated involuntarily.

[4]In the 2006 session, the Utah Legislature enacted legislation that addressed the issue of involuntary medication of incompetent defendants, essentially codifying the Sell factors. See Utah Code Ann. § 77-15-6.5.

See id. Although the State's interest in bringing a defendant to trial is important, this importance can be reduced by specific circumstances of the case. For example, if a defendant is likely to serve only a few years in prison and the amount of time the defendant has already spent in confinement waiting to be rendered competent has been two or three years (which could be credited toward any eventual sentence), the State's interests are lessened in importance. Moreover, if there is the possibility of involuntary civil commitment if a trial could not be held, this too would lessen the importance of the State's interests. See id. However, the Supreme Court was careful to note that the "potential for future confinement affects, but does not totally undermine, the strength of the need for prosecution." Id.

Second, the court must find that involuntarily medicating a defendant will significantly further the State's interest in bringing a defendant to trial, see Utah Code Ann. § 77-15-6.5(4)(d)(ii); that is, the court must find that the medication is both substantially likely to render the defendant competent to stand trial and substantially unlikely to have side effects that will interfere significantly with the defendant's ability to assist counsel in presenting a trial defense. See id. at 181. See also Utah Code Ann. § 77-15-6.5(3)(b)-(c)). Because different drugs have different side effects, the State "must propose a course of treatment in which it specifies the particular drug to be

administered," United States v. Evans, 404 F.3d 227, 240 (4th Cir. 2005), "including the dose range." Id. at 241. See also United State v. Algere, 396 F. Supp.2d 734, 741 (E.D. La. 2005) (the State must propose treatment specific to the defendant); United States v. Miller, 292 F. Supp.2d 163, 164 (D. Me. 2003) (the State must show that the "proposed regimen of antipsychotic medication is medically appropriate for a defendant in the condition and circumstances of this Defendant.") (emphasis added)).

Third, the court must find that means less intrusive than medication are unlikely to achieve substantially the same results. See id. See also Utah Code Ann. § 77-15-6.5(3)(a),(d). For example, if it were the case that the trial court could simply issue an order directing the defendant to take the medication and this would suffice, then there would clearly be a less intrusive means to rendering the defendant competent than forcibly medicating her.

Fourth, the trial court "must conclude that administration of the drugs is medically appropriate, i.e., in the patient's best medical interest in light of [her] medical condition." Id. (emphasis in original). See also Utah Code Ann. § 77-15-6.5(3)(e).

The foregoing legal standard "control[s] when the sole purpose of forced chemical treatment is to render a defendant competent for trial." United States v. Gomes, 387 F.3d 157, 160 (2d Cir. 2004). However, the Supreme Court also indicated that a

> court need not consider whether to allow forced medication for that kind of purpose, if forced medication is warranted for a different purpose, such as the purposes . . . related to the [defendant's] dangerousness, or purposes related to the [defendant's] own interests where refusal to take drugs puts [her] health gravely at risk.

Sell, 539 U.S. at 182-83 (emphasis in original). Thus, before proceeding to apply the Sell standard, the court must first consider whether involuntarily medicating Defendant is constitutionally justifiable on alternative grounds set forth by the Supreme Court, such as to render a defendant non-dangerous. See United States v. White, 431 F.3d 431, 435 (5th Cir. 2005) (in Sell, the Supreme Court admonished trial courts "to consider whether involuntary medication is appropriate on grounds of dangerousness before considering whether doing so would be appropriate to restore an inmate's competence to stand trial."); United States v. Morrison, 415 F.3d 1180, 1186 (10th Cir. 2005) (an inquiry into involuntarily medicating a defendant on dangerousness grounds should precede the inquiry required by Sell). See also Riggins, 504 U.S. at 135 (involuntary medication is constitutionally permissible if it is "essential for the sake of [the defendant's] own safety or the safety of others."); Harper, 494 U.S. at 227 (involuntary medication is constitutionally permissible if "the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest.").

Discussion

The State argues that Defendant's symptoms, especially her referential thinking, strongly suggest that she suffers from Psychotic Disorder, NOS. While at the State Hospital, she has made little, if any, progress in competency restoration. The State Hospital has exhausted all treatment modalities at its disposal in seeking to comply with the court's order to restore Defendant to competency with the exception of administering Defendant antipsychotic medication. Defendant has refused to participate in any type of therapy and has adamantly refused to consider taking antipsychotic medication, although treatment through medication has been offered to her.

According to the State, all of the Sell requirements are satisfied in Defendant's case. First, given the seriousness of the charges leveled against Defendant, bringing her to trial is an important State interest; second, involuntarily medicating Defendant will significantly further the State's important interest. According to the State, administering antipsychotic medication to Defendant is substantially likely to render Defendant competent to stand trial and substantially unlikely to have side effects that will interfere with her ability to assist counsel. Third, no less intrusive means are available to the State to restore Defendant to competency, and fourth, the administration of antipsychotic medication to Defendant is in her best medical

interest in light of her medical condition. For these reasons, the State argues that the court should permit the State Hospital to involuntarily medicate Defendant with antipsychotic medication.

Defendant argues that all of the Sell requirements are not satisfied in her case. Specifically, she asserts that involuntarily administering to her antipsychotic medication will not significantly further the State's interests in bringing her to trial. According to Defendant, the overwhelming experience of clinicians in forensic psychology and scholarly studies strongly suggest that antipsychotic medication is highly unlikely to restore to competence a person with Defendant's symptoms. Moreover, even if the administration of antipsychotic medication could successfully restore her to competency, their side affects would interfere with her ability to assist counsel in her defense.

I. Introduction

As noted above, the Sell factors need not be considered if there are reasons alternative to restoration of competency that constitutionally justify forcibly medicating Defendant, such as Defendant's dangerousness or the possibility that she may suffer grave health risks as a result of refusing medication. In Defendant's case, both parties acknowledge that so long as Defendant remains in the forensic unit of the State Hospital she is neither a danger to herself or others nor is her refusal to take

antipsychotic medication likely to pose any grave health risks. Although Defendant has occasionally fasted for extended periods of time, raising the possibility of a health risk, she has ever been violent or in any way assaultive towards hospital staff or medical personnel. At the February 16th hearing, the State's expert witnesses, Dr. Jeppson and Dr. Whitehead, both concluded that Defendant is neither gravely disabled as a result of her refusal to take medication nor is she a danger to herself or others while she remains in the controlled environment of the State Hospital.

Based upon the foregoing evidence, it is the court's conclusion that alternative reasons for authorizing involuntary medication, other than restoration to competency, are not present and, therefore, that the court must apply the factors enumerated in Sell to determine whether forced medication is constitutionally permitted in Defendant's case.

II. Important State Interest

The State has an interest in bringing Defendant to trial under Sell. That Defendant has been indicted on serious criminal offenses is evidenced by the significant length of incarceration she faces if convicted. See United State v. Gomes, 387 F.3d 157, 160 (2nd Cir. 2004) ("'Both the seriousness of the crime and [the defendant's] perceived dangerousness to society are evident from the substantial sentence [the defendant] faces if convicted.'"

(quoting United States v. Gomez, 289 F.3d 71, 86 (2nd Cir 2002), vacated and remanded by, 539 U.S. 939 (2003)). Defendant has been charged with two counts of aggravated sexual assault and one count of aggravated kidnaping, each of which carries a sentence of 6,10, or 15 years to life in prison. She has also been charged with two counts of aggravated burglary, each of which carries a sentence of 5 years to life in prison, and one count of conspiracy to commit kidnaping, which carries a sentence of 1 to 15 years. Clearly Defendant has been charged with serious crimes which the State has a significant interest in timely prosecuting. Nevertheless, the Sell Court also indicated that certain "circumstances may lessen the importance of [the State's] interest." Sell, 539 U.S. at 180. For example, "failure to take drugs voluntarily . . . may mean lengthy confinement in an institution for the mentally ill--and that would diminish the risks that ordinarily attach to freeing without punishment one who has committed a serious crime." Id.

The standard in Utah for involuntarily committing a person for mental health treatment requires that there be

> clear and convincing evidence that: (a) the proposed patient has a mental illness; (b) because of the proposed patient's mental illness [she] poses a substantial danger[5] . . . of physical injury to others or [her]self,

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[5]A person poses a "substantial danger" to others when, as a result of mental illness, his or her behavior places him or her

> (a) . . . at serious risk to: (I) commit suicide, (ii) inflict serious bodily injury on himself or herself; or (iii) because of his or her actions or inaction, suffer serious bodily injury because he or she is incapable of providing the basic necessities of life, such as food, clothing, and shelter; (b) . . . at serious risk to cause or attempt to cause serious bodily injury; or ©) has inflicted or

> which may include the inability to provide the basic necessities such as food, clothing, and shelter, if allowed to remain at liberty; ©) the patient lacks the ability to engage in a rational decision-making process regarding the acceptance of mental treatment as demonstrated by evidence of inability to weigh the possible risks of accepting or rejecting treatment; (d) there is no appropriate less-restrictive alternative to a court order of commitment; and (e) the local mental health authority can provide the individual with treatment that is adequate and appropriate to [her] conditions and needs.

Utah Code Ann. § 62A-15-631(10)(a)-(e). As previously discussed, the parties agree that Defendant is not a substantial danger to herself or others, though the State relies upon the caveat that this is so at least while she is confined in the State Hospital's Forensic Unit. Presumably, the State would argue that outside the State Hospital Defendant would pose a substantial danger to herself or others. Based upon the evidence presented to the court, it is not clear whether involuntary commitment is, at present, a realistic option in Defendant's case. If it is not, then the State's interest in prosecuting Defendant remains undiminished.

However, even if the conditions for involuntary commitment are satisfied, the "potential for future confinement affects, but does not totally undermine, the strength of the need for prosecution." Sell, 539 U.S. at 180. In Defendant's case, an involuntary

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attempted to inflict serious bodily injury on another.
Utah Code Ann. § 62A-15-602(13). "Serious bodily injury" is defined as "bodily injury which involves a substantial risk of death, unconsciousness, extreme physical pain, protracted and obvious disfigurement, or protracted loss or impairment of the function of a bodily member, organ, or mental faculty." Utah Code Ann. § 62A-15-602(12).

commitment could last for years or simply months. If Defendant is unlikely to face lengthy confinement, then the involuntary commitment would have little impact on the importance of the State's interest in bringing her to trial. See id. (". . . lengthy confinement in an institution for the mentally ill . . . would diminish the risks that ordinarily attach to freeing without punishment one who has committed a serious crime.") (emphasis added)). On the other hand, if Defendant were to face a significant length of time in confinement if involuntarily committed, the State makes the legitimate argument that this type of delay in bringing Defendant to trial "would likely diminish witness availability, recollection[,] and ability to testify accurately. It would also likely inhibit [Defendant's] ability to accurately remember events and facts, thus inhibiting her ability to assist in her own defense." State's Supplemental Mem. in Supp. at 8-9. See also id. ("[I]t may be difficult or impossible to try a defendant who regains competence after years of commitment during which memories may fade and evidence may be lost."). Thus, even if Defendant would face involuntary commitment, the State's interests in prosecuting Defendant are not significantly diminished. Therefore, the court's concludes that the State has shown by clear and convincing evidence that it has a significant interest in timely prosecuting defendant.

III. Involuntary Medication and Furthering the State's Interests

To determine that involuntary administration of antipsychotic medication would significantly further the State's interest in prosecuting defendant the court must find that treatment is (1) substantially likely to render Defendant competent to proceed to trial and (2) substantially unlikely to have side effects that will significantly undermine her ability to consult with her attorneys and assist them in presenting a defense. See Sell, 539 U.S. at 181.

A. Likelihood that Defendant Will Be Rendered Competent

Although all of the experts who testified at the February 16th hearing agreed that providing antipsychotic medication to a patient with Defendant's symptoms is essential to any treatment modality, they disagreed on whether involuntarily administering antipsychotic medication is substantially likely to render her competent to stand trial. On the one hand, Dr. Amador suggests that published research, rather than clinical experience, is the proper basis for making that determination, arguing that, while clinical experience is certainly important, practitioners' knowledge is limited to the location where they practice and the patients they see. According to Dr. Amador, this limitation mandates reference to published research whenever possible to avoid false assumptions and, ultimately, false conclusions about how a patient should be treated.

Relying on published research as well as their own experience, Dr. Morris and Dr. Amador each contend that it is highly unlikely that Defendant can be rendered competent to stand trial by forcibly medicating her with antipsychotic drugs. On the other hand, Dr. Jeppson and Dr. Whitehead relying primarily upon their own clinical experience and information on restoration rates from other hospitals, conclude that there is a substantial likelihood that Defendant will be restored to competency if given antipsychotic medication.

Each witness who testified at the February 16th hearing is knowledgeable and experienced. The court now must decide whose testimony is most persuasive and convincing. Dr. Morris testified that he reviewed Defendant's past competency evaluations, her treatment history, the affidavits of Dr. Jeppson and Dr. Whitehead, and interviewed Defendant once on the morning of the February 16th hearing. Dr. Amador testified that he reviewed evaluations, reports, and other materials related to Defendant and spent fifteen hours personally observing her over several years. His first interview occurred on September 18, 2003; the second on October 20, 2003, the third on November 3, 2003, and the last on August 10, 2004. He also reviewed materials collected by a defense investigator, which included many hours of interviews with family members and other individuals acquainted with Defendant. However, neither witness indicated that he had reviewed the State Hospital's

records in full, and their interaction with Defendant was at best limited.

As the State points out, neither Dr. Morris nor Dr. Amador had the quantity or quality of information about Defendant's mental health as Dr. Jeppson. Although Dr. Amador contends that being a treating physician is likely disadvantageous, the court disagrees. Dr. Jeppson's, and to a lesser extent Dr. Whitehead's, familiarity with Defendant's condition makes them better suited to know what type of treatment modality will assist Defendant and what the chances of success will be if Defendant is administered antipsychotic medication. Dr. Jeppson has treated Defendant at the State Hospital for over two years. Unlike Defendant's witnesses, Dr. Jeppson has had the advantage of seeing and interacting with Defendant on almost a weekly basis since March of 2004. He was aware of her condition when she was initially admitted and has been in the best position to witness any changes in her symptoms. This is an important factor the court must consider.

In addition, as Dr. Amador testified, it may be true that as a general matter there is a low likelihood that patients diagnosed with Delusional Disorder and whose psychosis has not been treated for many years can be restored to competency. This has certainly been the personal clinical experience of Dr. Morris and Dr. Amador. However, as important as the statistical data may be, in the court's view it is neither as authoritative nor weighty as the

testimony of Defendant's actual treating physician. It is not only competency restoration rates in general that the court is concerned about, but also the likelihood that this particular defendant's competency will be restored through the administration of antipsychotic medication. Dr. Jeppson and Dr. Whitehead have had significant success treating patients with symptoms similar to Defendant's. While their success rate in the clinical setting may be inconsistent with the statistical data, that is of lesser consequence because it is Dr. Jeppson himself who will continue to treat Defendant. Clearly, he has developed expertise in restoring delusional patients to competency notwithstanding the fact that there has been significant delay from the onset of psychosis to initial treatment. Dr. Jeppson's clinical experience, his success rate in restoring patients to competency who exhibit symptoms similar to Defendant's, his interaction with Defendant over the past two years, and the fact that he is the actual physician who will continue to treat Defendant trump any statistical data concerning general rates of successful restoration to competency of patients with Defendant's symptoms. Given these circumstances, Dr. Jeppson is in the best position to know the likelihood that Defendant will respond to his treatment plan and, ultimately, be restored to competency.

For the foregoing reasons, the court finds that the testimony of the State's witnesses is more persuasive on the issue of whether

the use of antipsychotic medication will render Defendant competent to proceed to trial. The court therefore finds by clear and convincing evidence that there is a substantial likelihood that if Defendant is administered antipsychotic medication pursuant to Dr. Jeppson's treatment plan, over time her delusional beliefs will become less prominent, she will become less preoccupied with her delusions, and, ultimately, her competency to proceed to trial will be restored.

B. Likelihood that Side Effects from Medication Will Affect Defendant's Ability to Consult with Counsel

Even if there is a substantial likelihood that the administration of antipsychotic medication to Defendant will render her competent to proceed, unless the proposed medication is substantially unlikely to have side effects that will interfere significantly with her ability to assist counsel in conducting a trial defense, the court cannot conclude that the involuntary administration of antipsychotic medication will further the State's interests. Dr. Jeppson, Dr. Whitehead, and Dr. Morris basically agree that the likely side effects to the medication would be fatigue, sedation, dry mouth, and blurry vision. Other possible, but less likely, side effects include rise in cholesterol levels, diabetes, constipation, tardive dyskinesia, orthostatic hypotension, and increased risk of heart attack. However, Dr. Jeppson indicated that the likely side effects are often time-limited. In his view, none of the likely side effects would

undermine Defendant's ability to assist her attorneys and, if successful, Defendant should have an increased ability to engage in rational decision making about her case. Dr. Whitehead testified that the likely side effects to the medication may cause discomfort but are not dangerous, and the problems associated with the unlikely side effects can be mitigated through careful monitoring. According to Dr. Whitehead, the side effects from the medication would not interfere with Defendant's ability to consult with her attorney and would help her organize her thinking, better assist her attorneys, and prepare a meaningful defense. Dr. Morris testified that because he believes the proposed medication will not restore Defendant to competency, giving her antipsychotic medication is not worth the risk of having Defendant suffer the possible side effects. In addition, however, Dr. Morris also testified that despite the risks, if Defendant were his patient he would attempt to medicate her with antipsychotic drugs.

Although Dr. Amador did not specifically testify to physical side effects of the proposed antipsychotic medication, he did state that forcibly medicating Defendant would be traumatic for her and would likely send her into a depression and make her vulnerable to symptoms of stress reaction and, potentially, Post-Traumatic Stress Disorder. These unfavorable emotional/ psychological side effects are likely to occur, he argued, because Defendant's delusions are intimately connected to who she is as a person and, therefore,

treatment could have a significant negative effect on her self-esteem. However, Dr. Amador did not testify that these types of side affects, if they did occur, would undermine Defendant's ability to assist her attorneys and present a defense.

Based upon the testimony provided, the court finds that there is a low probability that Defendant will suffer any debilitating or serious permanent physical side effects from being administered antipsychotic medication. In addition, although it is probable that Defendant will experience fatigue, sedation, dry mouth, etc. from the medication, the discomfort she will feel will likely be time-limited and, moreover, as Dr. Whitehead stated, their negative effects can be mitigated through careful monitoring. Importantly, if the medication is successful, Defendant will be in a better position to engage in rational discourse about her case, and the likely side effects will do nothing to diminish her ability to consult with her attorneys. As noted by Dr. Amador, Defendant may experience certain non-physical side effects, such as anxiety, trauma, depression, or elevated levels of stress. Given Defendant's strident opposition to being medicated, these side effects may be likely. However, no evidence was presented that the non-physical side effects will undermine Defendant's ability to assist her attorneys. Moreover, if the administration of antipsychotic medication is successful, it is probable that whatever anxiety, depression, or stress Defendant experiences will

be short-lived. For the reasons set forth above, the court finds by clear and convincing evidence that involuntarily administering antipsychotic medication to Defendant is substantially unlikely to have side effects that will interfere significantly with her ability to assist counsel in conducting a trial defense.

IV. Necessity of Involuntary Medication

Before the court may order antipsychotic drugs to be involuntarily administered, the "court must conclude that involuntary medication is necessary to further [the State's] interests." Id. at 181. To satisfy this requirement, the State must demonstrate that "alternative, less intrusive treatments [than involuntary medication] are []likely to achieve substantially the same results," id., and that there are no "less intrusive means for administering the drugs [than involuntary administration], e.g., a court order to the defendant backed by the contempt power." Id. Both Dr. Jeppson and Dr. Whitehead testified that Defendant has been offered various treatment modalities in an attempt to restore her to competency, including the voluntary administration of antipsychotic medication, but that she has been unwilling to participate in treatment in any meaningful way. Moreover, because Defendant believes that those involved in her care at the State Hospital are "evil" and are "working against God's plan," that cooperating with suggested treatment options is contrary to God's

will for her, and, finally, that she does not believe herself to be mentally ill, it is highly unlikely that she will, at some future time, opt to participate in treatment. According to Dr. Jeppson and Dr. Whitehead, as well as Dr. Nielsen, to the extent that Defendant refuses to participate with treatment options offered to her, the only alternative available for making progress towards competency restoration and amelioration of Defendant's mental illness is the administration of antipsychotic medication.

Based upon the evidence presented, the court finds by clear and convincing evidence that involuntary medication is necessary to further the State's interest and that there are no treatments less intrusive than administering antipsychotic medication likely to achieve substantially the same results.

V. Medical Appropriateness of Administering Antipsychotic Medication

Lastly, the court must determine "that the administration of drugs is medically appropriate, i.e., in [Defendant's] best medical interest in light of his medical condition." Id. Both Dr. Jeppson and Dr. Whitehead stated that the treatment of choice for a patient suffering from a psychotic disorder like Defendant's is the administration of antipsychotic medication. In addition, although there was some disagreement among the doctors about the dosages that should be given to Defendant in order to restore her to competency, there was little if any disagreement that the drugs Dr.

Jeppson plans to administer to Defendant are the kinds of antipsychotic drugs normally given to patients suffering from a mental illness similar to Defendant's. Dr. Jeppson testified that medicating Defendant is in her best medical interest because the therapeutic effect of the medication will be to give her a fuller, more functional life and it will allow her to proceed forward with her case. In addition, at present, Defendant's unwillingness to cooperate has made it difficult for Hospital staff to ensure that her basic health needs are met. Medicating Defendant will likely alleviate this problem. Dr. Whitehead also testified that medicating Defendant with antipsychotic drugs is in her best medical interest. The medication will allow her to organize and improve her thinking, relate more appropriately to her family and generally function better. Dr. Whitehead further testified that the alternative of simply warehousing Defendant at the State Hospital without treatment would clearly not be in her best interest.

Finally, the court notes that there is at least tacit agreement from Dr. Morris and Dr. Amador that administering antipsychotic medication to Defendant would be in her best medical interest. Although Dr. Morris and Dr. Amador disagreed with Dr. Jeppson and Dr. Whitehead about the efficacy of administering antipsychotic medication to Defendant, the likelihood of severe side effects would result, and whether she should be given drugs

against her will, they nevertheless agreed that if Defendant was their patient, they too would treat her with antipsychotic medication in order to improve her mental health and restore her to competency.

Based upon the foregoing evidence, and in light of Defendant's mental health condition, the court finds by clear and convincing evidence that administering antipsychotic medication to Defendant would be in her best medical interest.

Conclusion

Although criminal defendants found incompetent to proceed to trial have a liberty interest in being free from unwanted medication, in Sell v. United States the United States Supreme Court established a legal framework whereby a defendant's liberty interest in this regard may be overcome. That framework requires that before a defendant may be involuntarily medicated, the court must find by clear and convincing evidence that (1) important State interests are at stake; (2) involuntary medication will significantly further the State's interest, i.e., the medication is both substantially likely to render the defendant competent to stand trial and substantially unlikely to have side effects that will interfere significantly with the defendant's ability to assist counsel in conducting a trial defense; (3) involuntarily medicating a defendant is necessary to further the State's interests and that

less intrusive means considered by the court are unlikely to achieve substantially the same results; and (4) administration of the drugs is medically appropriate, i.e., in the patient's best medical interest in light of the defendant's medical condition.

Based upon a careful assessment of the expert testimony provided at the February 16th hearing and the foregoing standard set forth by the Supreme Court, the court finds that clear and convincing evidence has been presented sufficient to satisfy all four requirements. Therefore, the court grants the State's Motion to Compel Medication.

DATED this 20 day of June, 2006.

BY THE COURT:

Judge Judith S. Atherton
Third Judicial District Court

Certificate of Delivery

I certify that a true and correct copy of the foregoing Ruling on Motion to Compel Medication was mailed or faxed on the _____ day of May, 2006, to the following:

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